*(attached as **Exhibit 4**). For purposes of this classification only, the term "disproportionate share hospital" refers to any acute hospital that exhibits a payor mix where a minimum of sixty-three percent of the acute hospital's gross patient service revenue is attributable to Title XVIII and Title XIX of the Federal Social Security Act, other government payors and free care. Payments shall be made during the term of the RY95 hospital contract.*

*2. **Basic Federally-Mandated Disproportionate Share Adjustment***
(Total Funding: $200,000)

*The eligibility criteria and payment formula for this DSH classification are described in regulations of the Rate Setting Commission pursuant to its ISA with the Division, and in accordance with the minimum requirements of 42 U.S.C. §1396r-4. (See 114.1 CMR 36.13(10)(b) attached as **Exhibit 4**.) Payments will be made to qualifying hospitals by the Division during the term of the RY95 hospital contract.*

*3. **Disproportionate Share Adjustment for Safety Net Providers***

A disproportionate share safety net adjustment factor for all eligible hospitals shall be determined.

This class of hospital was identified and included to ensure that those hospitals which provide the services most critical to the poor are reimbursed for their overload of free care so that they can continue to provide the services which we deem crucial to the provision of adequate health care.

a. Determination of Eligibility

The disproportionate share adjustment for safety net providers is an additional payment for all hospitals eligible for the basic federally-mandated disproportionate share adjustment pursuant to Section IV.2.C.2 above, which also meet the following additional criteria:

- *i. is a public hospital;*
- *ii. has a volume of free care charges in FY91 which is at least 10% of total charges;*
- *iii.. is an essential safety net provider in its service area, as demonstrated by delivery of services to populations with special needs, including persons with AIDS, trauma victims, high-risk neonates, and indigent patients without access to other providers;*
- *iv. is a municipality which has completed an agreement with the Department of Public Welfare for an intergovernmental transfer of funds to the Medicaid program for the federally-mandated disproportionate share adjustment for safety net providers.*

b. Payment Methodology

An additional adjustment shall be calculated for federally-mandated disproportionate

share hospitals which are eligible for the safety net provider adjustment.

i. This payment amount shall be reasonably related to the costs of services provided to patient eligible for medical assistance under Title XIX, or to low-income patients.

ii. This payment adjustment shall be based on an agreement between the Department and the qualifying hospital for a specified amount of money to be paid as an intergovernmental transfer. Each qualifying hospital shall make an initial transfer of funds to the Department. The Department shall then make a disproportionate share payment adjustment to the qualifying hospital equal to two times the public municipal revenue transferred by that hospital to the state; provided that such payment shall be adjusted if necessary, to ensure that a qualifying hospital's total disproportionate share adjustment payments in a fiscal year under the State Plan do not exceed 180% of such hospital's total unreimbursed free care and unreimbursed Medicaid costs for the same fiscal year. Such unreimbursed costs shall be calculated by the Department using the best data available, as determined by the Department, for the fiscal year.

iii. The payment of the safety net adjustment to a qualifying hospital in any rate year shall be contingent upon (a) the availability of municipal funds through the qualifying hospital to support an intergovernmental transfer and (b) the continued availability of federal financing participation for such payments.

4. Uncompensated Care Disproportionate Share Adjustment

*Hospitals eligible for this adjustment are those acute facilities that incur "free care costs" as defined in regulations of the Department of Medical Security (DMS) at 117 CMR 7.00 (attached as **Exhibit 5**). The payment amounts for eligible hospitals participating in the free care pool are determined and paid by the Department of Medical Security in accordance with its regulations at 117 CMR 7.00. Eligible hospitals will receive these payments on a periodic basis during the term of their RY95 Medicaid contract with the Division.*

To qualify for a DSH payment adjustment under any classification within Section IV.2.C, a hospital must meet the obstetrical staffing requirements described in Title XIX at 42 U.S.C. §1396r-4(d) or qualify for the exemption described at 42 U.S.C. §1396r-4(d)(2).

D. Treatment of Reimbursement for Recipients in the Hospital on the Effective Date of the Hospital Contract

Reimbursement to participating hospitals for services provided to Medicaid recipients who are at acute inpatient status prior to October 1, 1994 and who remain at acute inpatient status on October

1, 1994 shall continue to be at the hospital's rates established prior to the RY95 RFA.

E. Future Rate Years

Adjustments may be made each rate year to update rates.

F. Errors in Calculation of Pass-through Amounts, Direct Medical Education Cost or Capital Costs

If a transcription error occurred or if the incorrect line was transcribed in the calculation of the RY95 pass-through costs, direct medical education costs or capital costs, resulting in an amount not consistent with the methodology, a correction can be made at any time during the initial term of the contract upon agreement by both parties. Such corrections will be made to the final hospital-specific rate retroactive to the effective date of the contract resulting from the RFA but will not affect computation of the statewide standard payment amount or of any of the efficiency standards applied to inpatient and outpatient costs, or to capital costs. Hospitals must submit copies of the relevant report as referenced in Data Sources (Section IV.1), highlighting items found to be in error, to Kiki Feldmar, Division of Medical Assistance, Benefit Services, 5th floor, 600 Washington Street, Boston, MA 02111 during the term of the contract to initiate a correction.

State Plan Under Title XIX of the Social Security Act
State: Massachusetts
Institutional Reimbursement

Exhibit List

130 CMR 415.415; 130 CMR 415.416 (Exhibit 1)

130 CMR 415.404(B) (Exhibit 2)

Transfer Matrices (Exhibit 3)

114.1 CMR 36.13(10) (Exhibit 4)

117 CMR 7.00 (Exhibit 5)

State Plan Under Title XIX of the Social Security Act
State: Massachusetts
Institutional Reimbursement

Exhibit 1

130 CMR 415.415; 130 CMR 415.416

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415.414: continued

(C) If, as the result of a concurrent review, the Division or its agent determines that a recipient's stay is no longer administratively necessary due to the availability of an appropriate placement, the Division will not pay for any part of the hospital stay that follows ten days after the date of notice to the hospital and to the recipient that the stay is no longer administratively necessary.

(D) If, as the result of a review, the Division or its agent determines that there was no medical or administrative necessity for a hospital admission, a hospital stay, or any part of a hospital stay, the Division will not pay for that admission, stay, or part of a stay.

(E) If, as the result of a review, the Division or its agent denies the need for any hospital service delivered to a recipient during a hospital stay, the Division will not pay for that service.

(F) If a hospital stay or service is reviewed by the Division or its agent concurrently with a recipient's acute hospital admission or stay and the admission, service, and stay, or any part of it, are certified at the time of review as medically or administratively necessary and appropriate, the Division will treat that certification as binding for payment purposes.

(G) If, as the result of a review, the Division or its agent determines that any hospital admission, stay, or service provided to a recipient was subject to a service limitation (see 130 CMR 450.106) and was delivered without obtaining authorization from the recipient's primary-care provider, the Division will not pay for that admission, stay, or service.

(H) Certification of out-of-state hospital claims must be made by the organization responsible for that state's Medical Assistance Program utilization review.

415.415: Reimbursable Administrative Days

(A) Administrative days as defined in 130 CMR 415.402 are reimbursable if the following conditions are met:

(1) the recipient requires an admission to a hospital or a continued stay in a hospital for reasons other than the need for services that can only be provided in an acute inpatient hospital as defined in 130 CMR 415.402 (see 130 CMR 415.415(B) for examples); and

(2) a hospital is making regular efforts to discharge the recipient to the appropriate setting. These efforts must be documented according to the procedures described in 130 CMR 450.205. The regulations covering discharge-planning standards described in 130 CMR 415.419 must be followed, but they do not preclude additional, effective discharge-planning activities.

(B) Examples of situations that may require hospital stays at less than a hospital level of care include, but are not limited to, the following.

(1) A recipient is awaiting transfer to a chronic disease hospital, rehabilitation hospital, nursing facility, or any other institutional placement.

(2) A recipient is awaiting arrangement of home services (nursing, home health aide, durable medical equipment, personal care attendant, therapies, or other community-based services).

(3) A recipient is awaiting arrangement of residential, social, psychiatric, or medical services by a public or private agency.

(4) A recipient with lead poisoning is awaiting deleading of his or her residence.

(5) A recipient is awaiting results of a report of abuse or neglect made to any public agency charged with the investigation of such reports.

(6) recipient in the custody of the Department of Social Services is awaiting foster care when other temporary living arrangements are unavailable or inappropriate.

415.415: continued

(7) A recipient cannot be treated or maintained at home because the primary caregiver is absent due to medical or psychiatric crisis, and a substitute caregiver is not available.
(8) A recipient is awaiting a discharge from the hospital and is receiving skilled nursing or other skilled services. Skilled services include, but are not limited to:
(a) maintenance of tube feedings;
(b) ventilator management;
(c) dressings, irrigations, packing, and other wound treatments;
(d) routine administration of medications;
(e) provision of therapies (respiratory, speech, physical, occupational, etc.);
(f) insertion, irrigation, and replacement of catheters; and
(g) intravenous, intramuscular, or subcutaneous injections, or intravenous feedings (for example, total parenteral nutrition.)

415.416: Nonreimbursable Administrative Days

Administrative days are not reimbursable when:

(A) a hospitalized recipient is awaiting an appropriate placement or services that are currently available but the hospital has not transferred or discharged the recipient because of the hospital's administrative or operational delays;

(B) the Division or its agent determines that appropriate noninstitutional or institutional placement or services are available within a reasonable distance of the recipient's noninstitutional (customary) residence and the recipient, the recipient's family, or any person legally responsible for the recipient refuses the placement or services; or

(C) the Division or its agent determines that appropriate noninstitutional or institutional placement or services are available within a reasonable distance of the recipient's noninstitutional (customary) residence and advises the hospital of the determination, and the hospital or the physician refuses or neglects to discharge the recipient.

415.417: Notification of Denial, Reconsideration, and Appeals

(A) Notification of Denial. The Division or its agent shall notify the recipient, the hospital, and the recipient's attending physician whenever it determines as part of a concurrent review that the hospital admission or stay, or any part thereof, is not medically or administratively necessary. The Division or its agent shall notify the hospital and the recipient's attending physician whenever it determines as part of a concurrent or retrospective review that the hospital stay is or was no longer medically necessary but is or was administratively necessary. The Division or its agent shall notify the hospital and the recipient whenever it determines as part of a concurrent review that a hospital stay is no longer administratively necessary due to the refusal of an appropriate placement.

(B) Reconsideration. An agent of the Division under 130 CMR 415.000 may provide an opportunity for reconsideration of a determination made by that agent. If a reconsideration is available, notice of the agent's determination will include written notice of: the right to a reconsideration; the time within and manner in which a reconsideration must be requested; and the time within which a decision will be rendered. A hospital, a physician, or a recipient entitled to have a determination reconsidered must request and have a reconsideration determination given before requesting a hearing under 130 CMR 415.417(C).

(C) Appeals to the Division.
(1) A recipient may request a fair hearing before the Division when the Division or its agent determines as the result of a concurrent review that a continued stay is not administratively necessary due to the availability of an appropriate placement as described in 130 CMR 415.415.

State Plan Under Title XIX of the Social Security Act
State: Massachusetts
Institutional Reimbursement

Exhibit 2

130 CMR 415.404(B)

415.403: continued

(B) Recipients of the Emergency Aid to the Elderly, Disabled and Children Program. For information on reimbursable services for recipients of the Emergency Aid to the Elderly, Disabled and Children Program (category of assistance 4), see 130 CMR 450.111.

415.404: Provider Eligibility

Payment for the services described in 130 CMR 415.000 will be made only to acute inpatient hospitals participating in the Medical Assistance Program as of the date of service.

(A) In State. To participate in the Medical Assistance Program, an acute inpatient hospital located in Massachusetts must:

(1) be licensed as a hospital by the Massachusetts Department of Public Health;

(2) have a signed provider agreement that specifies a reimbursement methodology with the Division of Medical Assistance; and

(3) participate in the Medicare program.

(B) Out of State.

(1) Out-of-state acute inpatient hospital services are reimbursable in any one of the following instances:

(a) emergency care hospital services are provided to a recipient;

(b) hospital services are provided to a recipient who lives in a community near the border of Connecticut, Maine, New Hampshire, New York, Rhode Island, or Vermont and for whom the out-of-state hospital is nearer than one in Massachusetts providing equivalent medical services;

(c) hospital services are provided to a recipient who is authorized to reside or who is placed out of state by the Massachusetts Department of Social Services; or

(d) hospital services are provided to a recipient whose medical needs cannot be met by a Massachusetts medical provider. In this instance, the out-of-state hospital must make a request for prior authorization before the recipient is admitted to the hospital.

(2) To participate in the Massachusetts Medical Assistance Program, an out-of-state acute inpatient hospital must obtain a Massachusetts Medical Assistance provider number and meet the following criteria:

(a) be approved as an acute inpatient hospital by the governing or licensing agency in its state;

(b) participate in the Medicare program; and

(c) participate in that state's Medical Assistance Program (or equivalent).

(3) Payment to an out-of-state hospital will be made in accordance with the Medical Assistance Program (or equivalent) fee schedule of that state.

415.405: Utilization Management Program and Mental Health and Substance Abuse Admission Screening Requirements

(A) Utilization Management Program. The Division will pay for medical procedures and related hospital stays that are subject to the Utilization Management Program only if the requirements of the program, as described in 130 CMR 450.207 through 450.211 are satisfied. Appendix E of the *Acute Inpatient Manual* contains the name, address, and telephone number of the contact organization for the Utilization Management Program and describes the information that must be provided as part of the review process.

(B) Mental Health and Substance Abuse Admissions. The Division will pay for mental health and substance abuse services provided in an acute or nonacute inpatient setting only if the admitting provider has satisfied the screening program requirements at 130 CMR 450.125. Appendix F of the *Acute Inpatient Hospital Manual* contains the name, address, and telephone number of the contact organization for the screening program.

State Plan Under Title XIX of the Social Security Act
State: Massachusetts
Institutional Reimbursement

Exhibit 3

Transfer Matrices

TRANSFERRING RULES- WITHIN A HOSPITAL

MANAGED CARE RECIPIENT

FROM : TRANSFERRING UNIT	TO: RECEIVING UNIT: MED SURG	** PSYCH	SUB\ABUSE
MH\SA NETWORK HOSPITAL	MED\SURG	TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY	TRANSFERRING UNIT: TRANSFER PER DIEM RECEIVING UNIT: MH\SA CONTRACT RATE	TRANSFERRING UNIT: TRANSFER PER DIEM RECEIVING UNIT: MH\SA CONTRACT RATE
	** PSYCHIATRIC	TRANSFERRING UNIT: MH\SA CONTRACT RATE RECEIVING UNIT: TRANSFER PER DIEM	TRANSFERRING & RECEIVING UNITS: MH\SA CONTRACT RATE	TRANSFERRING & RECEIVING UNITS: MH\SA CONTRACT RATE
	SUBSTANCE ABUSE	TRANSFERRING UNIT: MH\SA CONTRACT RATE RECEIVING UNIT: TRANSFER PER DIEM	TRANSFERRING & RECEIVING UNITS: MH\SA CONTRACT RATE	TRANSFERRING & RECEIVING UNITS: MH\SA CONTRACT RATE
NON-MH\SA NETWORK HOSPITAL	MED\SURG	TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY	TRANSFERRING UNIT: TRANSFER PER DIEM RECEIVING UNIT: NOT REIMBURSABLE	TRANSFERRING UNIT: TRANSFER PER DIEM RECEIVING UNIT: NOT REIMBURSABLE
	** PSYCHIATRIC	TRANSFERRING UNIT:* NOT REIMBURSABLE RECEIVING UNIT: TRANSFER PER DIEM	TRANSFERRING * & RECEIVING UNITS: NOT REIMBURSABLE	TRANSFERRING * & RECEIVING UNITS: NOT REIMBURSABLE
	SUBSTANCE ABUSE	TRANSFERRING UNIT:* NOT REIMBURSABLE RECEIVING UNIT: TRANSFER PER DIEM	TRANSFERRING * & RECEIVING UNITS: NOT REIMBURSABLE	TRANSFERRING * & RECEIVING UNITS: NOT REIMBURSABLE

NON-MANAGED CARE RECIPIENT

MED SURG	** PSYCH	SUB\ABUSE
TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY	TRANSFERRING UNIT: TRANSFER PER DIEM RECEIVING UNIT: PSYCH PER DIEM	TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY
TRANSFERRING UNIT: PSYCH PER DIEM RECEIVING UNIT: TRANSFER PER DIEM	TRANSFERRING & RECEIVING UNITS: PSYCH PER DIEM	TRANSFERRING UNIT: PSYCH PER DIEM RECEIVING UNIT: TRANSFER PER DIEM
TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY	TRANSFERRING UNIT: TRANSFER PER DIEM RECEIVING UNIT: PSYCH PER DIEM	TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY
TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY	TRANSFERRING UNIT: TRANSFER PER DIEM RECEIVING UNIT PSYCH PER DIEM	TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY
TRANSFERRING UNIT: PSYCH PER DIEM RECEIVING UNIT: TRANSFER PER DIEM	TRANSFERRING & RECEIVING UNITS: PSYCH PER DIEM	TRANSFERRING UNIT: PSYCH PER DIEM RECEIVING UNIT: TRANSFER PER DIEM
TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY	TRANSFERRING UNIT: TRANS PER DIEM RECEIVING UNIT: PSYCH PER DIEM	TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY

IN CASES OF AN EMERGENCY ADMISSION OF A MANAGED CARE RECIPIENT IN A NON-NETWORK HOSPITAL, THE HOSPITAL MUST FOLLOW AUTHORIZATION PROCEDURES OUTLINED IN 106 CMR 450.125, AND SHALL BE REIMBURSED BY THE DIVISION'S MH\SA PROVIDER AT THE CURRENT ACUTE HOSPITAL RFA RATE FOR PSYCHIATRIC AND SUBSTANCE ABUSE SERVICES.

* IN CASES INVOLVING A TRANSFER TO OR FROM A DMH REPLACEMENT UNIT, SUBSTITUTE THE DMH CONTRACT RATE IN THE ABOVE MATRIX WHERE APPROPRIATE. A DMH RATE CAN APPLY IN CIRCUMSTANCES WHERE THE MATRIX INDICATES THE SERVICE IS NOT REIMBURSABLE. ALL OTHER RULES RELATED TO TRANSFERS WITHIN A HOSPITAL SHALL APPLY.

TRANSFERRING RULES- WITHIN A HOSPITAL

MANAGED CARE RECIPIENT

FROM : TRANSFERRING UNIT	TO: RECEIVING UNIT: MED SURG	** PSYCH	SUB\ABUSE
MH\SA NETWORK HOSPITAL	MED\SURG	TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY	TRANSFERRING UNIT: TRANSFER PER DIEM RECEIVING UNIT: MH\SA CONTRACT RATE	TRANSFERRING UNIT: TRANSFER PER DIEM RECEIVING UNIT: MH\SA CONTRACT RATE
	** PSYCHIATRIC	TRANSFERRING UNIT: MH\SA CONTRACT RATE RECEIVING UNIT: TRANSFER PER DIEM	TRANSFERRING & RECEIVING UNITS: MH\SA CONTRACT RATE	TRANSFERRING & RECEIVING UNITS: MH\SA CONTRACT RATE
	SUBSTANCE ABUSE	TRANSFERRING UNIT: MH\SA CONTRACT RATE RECEIVING UNIT: TRANSFER PER DIEM	TRANSFERRING & RECEIVING UNITS: MH\SA CONTRACT RATE	TRANSFERRING & RECEIVING UNITS: MH\SA CONTRACT RATE
NON-MH\SA NETWORK HOSPITAL	MED\SURG	TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY	TRANSFERRING UNIT: TRANSFER PER DIEM RECEIVING UNIT: NOT REIMBURSABLE	TRANSFERRING UNIT: TRANSFER PER DIEM RECEIVING UNIT: NOT REIMBURSABLE
	** PSYCHIATRIC	TRANSFERRING UNIT:* NOT REIMBURSABLE RECEIVING UNIT: TRANSFER PER DIEM	TRANSFERRING * & RECEIVING UNITS: NOT REIMBURSABLE	TRANSFERRING * & RECEIVING UNITS: NOT REIMBURSABLE
	SUBSTANCE ABUSE	TRANSFERRING UNIT:* NOT REIMBURSABLE RECEIVING UNIT: TRANSFER PER DIEM	TRANSFERRING * & RECEIVING UNITS: NOT REIMBURSABLE	TRANSFERRING * & RECEIVING UNITS: NOT REIMBURSABLE

NON-MANAGED CARE RECIPIENT

MED SURG	** PSYCH	SUB\ABUSE
TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY	TRANSFERRING UNIT: TRANSFER PER DIEM RECEIVING UNIT: PSYCH PER DIEM	TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY
TRANSFERRING UNIT: PSYCH PER DIEM RECEIVING UNIT: TRANSFER PER DIEM	TRANSFERRING & RECEIVING UNITS: PSYCH PER DIEM	TRANSFERRING UNIT: PSYCH PER DIEM RECEIVING UNIT: TRANSFER PER DIEM
TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY	TRANSFERRING UNIT: TRANSFER PER DIEM RECEIVING UNIT: PSYCH PER DIEM	TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY
TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY	TRANSFERRING UNIT: TRANSFER PER DIEM RECEIVING UNIT PSYCH PER DIEM	TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY
TRANSFERRING UNIT: PSYCH PER DIEM RECEIVING UNIT: TRANSFER PER DIEM	TRANSFERRING & RECEIVING UNITS: PSYCH PER DIEM	TRANSFERRING UNIT: PSYCH PER DIEM RECEIVING UNIT: TRANSFER PER DIEM
TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY	TRANSFERRING UNIT: TRANS PER DIEM RECEIVING UNIT: PSYCH PER DIEM	TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY

* IN CASES OF AN EMERGENCY ADMISSION OF A MANAGED CARE RECIPIENT IN A NON-NETWORK HOSPITAL, THE HOSPITAL MUST FOLLOW AUTHORIZATION PROCEDURES OUTLINED IN 106 CMR 450.125, AND SHALL BE REIMBURSED BY THE DIVISION'S MH\SA PROVIDER AT THE CURRENT ACUTE HOSPITAL RFA RATE FOR PSYCHIATRIC AND SUBSTANCE ABUSE SERVICES.

** IN CASES INVOLVING A TRANSFER TO OR FROM A DMH REPLACEMENT UNIT, SUBSTITUTE THE DMH CONTRACT RATE IN THE ABOVE MATRIX WHERE APPROPRIATE. A DMH RATE CAN APPLY IN CIRCUMSTANCES WHERE THE MATRIX INDICATES THE SERVICE IS NOT REIMBURSABLE. ALL OTHER RULES RELATED TO TRANSFERS WITHIN A HOSPITAL SHALL APPLY.

TRANSFERRING RULES- BETWEEN TWO HOSPITALS
FOR NON-MANAGED CARE RECIPIENTS ONLY

MH\SA NETWORK
OR NON-MH\SA
NETWORK HOSPITAL

TO : RECEIVING HOSPITAL	MED SURG	** PSYCH	SUB\ABUSE
FROM : TRANSFERRING HOSPITAL			
MED\SURG	TRANSFERRING HOSP: TRANSFER PER DIEM RECEIVING HOSP: SPAD	TRANSFERRING HOSP: TRANSFER PER DIEM RECEIVING HOSP: PSYCH PER DIEM	TRANSFERRING HOSP: TRANSFER PER DIEM RECEIVING HOSP: SPAD
MH\SA NETWORK OR NON-MH\SA NETWORK HOSPITAL			
** PSYCHIATRIC	TRANSFERRING HOSP: PSYCH PER DIEM RECEIVING HOSP: SPAD	TRANSFERRING HOSP: PSYCH PER DIEM RECEIVING HOSP: PSYCH PER DIEM	TRANSFERRING HOSP: PSYCH PER DIEM RECEIVING HOSP: SPAD
SUBSTANCE ABUSE	TRANSFERRING HOSP: TRANSFER PER DIEM RECEIVING HOSP: SPAD	TRANSFERRING HOSP: TRANSFER PER DIEM RECEIVING HOSP: PSYCH PER DIEM	TRANSFERRING HOSP: TRANSFER PER DIEM RECEIVING HOSP: SPAD

IN CASES OF AN EMERGENCY ADMISSION OF A MANAGED CARE RECIPIENT IN A NON-NETWORK HOSPITAL,THE HOSPITAL MUST FOLLOW AUTHORIZATION PROCEDURES OUTLINED IN 106 CMR 450.125, AND SHALL BE REIMBURSED BY THE DIVISION'S MH\SA PROVIDER AT THE CURRENT ACUTE HOSPITAL RFA RATE FOR PSYCHIATRIC AND SUBSTANCE ABUSE SERVICES.

* IN CASES INVOLVING A TRANSFER TO OR FROM A DMH REPLACEMENT UNIT, SUBSTITUTE THE DMH CONTRACT RATE IN THE ABOVE MATRIX WHEN APPROPRIATE. A DMH RATE CAN APPLY IN CIRCUMSTANCES WHERE THE MATRIX INDICATES THE SERVICE IS NOT REIMBURSABLE. ALL OTHER RULES RELATED TO TRANSFERS BETWEEN TWO HOSPITALS SHALL APPLY.

State Plan Under Title XIX of the Social Security Act
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Institutional Reimbursement

Exhibit 4

114 CMR 36.13(10)

36.13: continued

(d) Rates of payment for emergency services provided by ambulance services are established according to the methodology set forth in 114.1 CMR 36.13(8)(g).
(e) Rates of payment for emergency dialysis services are established according to the methodology set forth in 114.1 CMR 36.13(8)(h).
(f) Rates of payment for emergency psychiatric day treatment are established according to the methodology set forth in 114.1 CMR 36.13(8)(i).
(g) Rates of payment for emergency dental services are established according to the methodology set forth in 114.1 CMR 36.13(8)(j).
(h) Payment for emergency inpatient admissions is made using the transfer per diem rate of payment, established according to the methodology set forth in 114.1 CMR 36.13 S.(4), up to the hospital-specific standard payment amount per discharge, established according to the methodology set forth in 114.1 CMR 36.13(2). Hospitals must notify the Division of Medical Assistance within 24 hours of admitting a Medicaid beneficiary in order to be eligible for payment pursuant to 114.1 CMR 36.13(9).

(10) Classifications of Disproportionate Share Hospitals (DSHs) and Payment Adjustments. The Medicaid program will assist hospitals who carry a disproportionate financial burden of caring for the uninsured and low income persons of the Commonwealth. In accordance with Title XIX rules and requirements, Medicaid will make an additional payment adjustment above the rates established under 114.1 CMR 36.13(10) to hospitals which qualify for such an adjustment under any one or more of the following classifications. Medicaid participating hospitals may qualify for adjustments and may receive them at any time throughout the year. Eligibility requirements for each type of disproportionate share adjustment and the methodology for calculating those adjustments is described below. Medicaid payment adjustments for disproportionate share contribute toward funding of allowable uncompensated care costs.

When hospitals apply to participate in the Medicaid program, their eligibility and the amount of their adjustment shall be determined. As new hospitals apply to become Medicaid providers, they may qualify for adjustments if they meet the criteria under one or more of the following DSH classifications (114.1 CMR 36.13(10)(a) through (e). If a hospital's Medicaid contract is terminated, any adjustment will be prorated for the portion of the year during which it had a contract, the remaining funds it would have received will be apportioned to remaining eligible hospitals. This means that some disproportionate share adjustments may require recalculation. Hospitals will be informed if an adjustment amount should change due to reapportionment among the qualified group and will be told how overpayments or underpayments by the Division will be handled at that time.

To qualify for a DSH payment adjustment under any classification within 114.1 CMR 36.13(10), a hospital must meet the obstetrical staffing requirements described in Title XIX at 42 U.S.C. § 1396r-4(d) or qualify for the exemption described at 42 U.S.C. § 1396r-4(d)(2).

(a) High Public Payer Hospitals: Disproportionate Share Status under C.495.

1. Eligibility. Hospitals determined eligible for disproportionate share status pursuant to 114.1 CMR 36.10 are eligible for this adjustment.

2. Calculation of Adjustment.

a. The Division of Medical Assistance will allocate $11.7 million for this payment adjustment.

b. The Commission will then calculate for all acute care hospitals the ratio of their allowable free care charges, as defined in M.G.L. c. 118F, § 2, to total charges, for the period October 1, 1991 through September 30, 1992. The Commission will obtain allowable free care charge data from the Department of Medical Security.

c. The Commission will then calculate the statewide average of the ratios of allowable free care to total charges determined in 114.1 CMR 36.13(10)(a)2.b.

d. The Commission will then determine the higher of (i) the ratio determined in 114.1 CMR 36.13(10)(a)2.b. minus the mean calculated in 114.1 CMR 36.13(10)(a)2.c.; or (ii) zero.

36.13: continued

e. Hospitals for whom the amount determined in 114.1 CMR 36.13(10)(a)2.d. is greater than zero qualify for a High Public Payer Hospitals adjustment. The Commission will multiply each qualifying hospital's FY92 allowable free care charges by the hospital's most current cost to charge ratio as of October 1, 1993, as calculated pursuant to 114.1 CMR 36.09 to determine allowable free care costs.

f. The Commission will then determine the sum of the amounts determined in 114.1 CMR 36.13(a)2.e. for all hospitals that qualify for a High Public Payer Hospitals adjustment.

g. Each hospital's FY94 High Public Payer Hospitals adjustment is equal to the amount specified in 114.1 CMR 36.13(10)(a)2.a. multiplied by the amount determined in 114.1 CMR 36.13(10)(a)2.e. and divided by the amount determined in 114.1 CMR 36.13(10)(a)2.f.

(b) Basic Federally - Mandated Disproportionate Share Adjustment.

1. The Commission will determine a federally-mandated Medicaid disproportionate share adjustment for all eligible hospitals, using the data and methodology described below. The Commission will use the following data sources in its determination of the federally-mandated Medicaid disproportionate share adjustment, unless the specified data source is unavailable. If the specified data source is unavailable, then the Commission will determine and use the best alternative data source.

a. The Commission will use free care charge data from the Department of Medical Security.

b. The prior year RSC-403 report will be used to determine Medicaid days, total days, Medicaid inpatient net revenues, and total inpatient charges.

c. The hospital's audited financial statements for the prior year will be used to determine the state and/or local cash subsidy.

2. The Commission will calculate a threshold Medicaid inpatient utilization rate to be used as a standard for determining the eligibility of acute care hospitals for the federally-mandated disproportionate share adjustment. The Commission will determine such threshold as follows:

a. First, calculate the statewide weighted average Medicaid inpatient utilization rate. This will be determined by dividing the sum of Medicaid inpatient days for all acute care hospitals in the state by the sum of total inpatient days for all acute care hospitals in the state.

b. Second, calculate the statewide weighted standard deviation for Medicaid inpatient utilization statistics. This will be determined according to the following formula:

$$\sqrt{\frac{\sum\left(\left(\text{average days}\right)\left(\text{total days}\right)\right)\left(\frac{\left(\text{total days}\right)\times\left(\text{Medicaid days}\right)^2}{\left(\Sigma\ \text{total days}\right)}\right) - \left(\Sigma\ \text{Medicaid days}\right)^2}{N}}$$

Where N = number of hospitals, and average days = statewide sum of total days, divided by the number of hospitals.

c. Third, add the statewide weighted standard deviation for Medicaid inpatient utilization to the statewide average Medicaid inpatient utilization rate. The sum of these two numbers will be the threshold Medicaid inpatient utilization rate.

d. The Commission will then calculate each hospital's Medicaid inpatient utilization rate by dividing each hospital's Medicaid inpatient days by its total inpatient days. If this hospital-specific Medicaid inpatient utilization rate equals or exceeds the threshold Medicaid inpatient utilization rate calculated pursuant to 114.1 CMR 36.13(10)(b)2.c., then the hospital will be eligible for the federally-mandated Medicaid disproportionate share adjustment under the Medicaid utilization method.

36.13: continued

3. The Commission will then calculate each hospital's low-income utilization rate as follows:

a. First, calculate the Medicaid and subsidy share of gross revenues according to the following formula:

$$\frac{\text{Medicaid gross revenues + state and local government cash subsidies}}{\text{Total revenues + state and local government cash subsidies}}$$

b. Second, calculate the free care percentage of total inpatient charges by dividing the inpatient share of free care charges less the portion of state and local government cash subsidies for inpatient services by total inpatient charges.

c. Third, compute the low-income utilization rate by adding the Medicaid and subsidy share of total revenues calculated pursuant to 114.1 CMR 36.13(10)(b)3.a. to the free care percentage of total inpatient charges calculated pursuant to 114.1 CMR 36.13(10)(b)(3)b. If the low-income utilization rate exceeds 25%, the hospital will be eligible for the federally-mandated disproportionate share adjustment under the low-income utilization rate method.

4. Additional Criteria for Eligibility:

a. The hospitals identified as eligible for federally-mandated disproportionate share adjustments must have at least two obstetricians who have staff privileges at the hospital unless:

i. the hospital has inpatients predominantly under 18 years of age; or

ii. the hospital does not offer non-emergency obstetric services to the general population as of December 22, 1987.

5. Payment Methodology. The payment under the federally-mandated disproportionate share adjustment requirement will be calculated as follows:

a. For each hospital deemed eligible for the federally-mandated Medicaid disproportionate share adjustment under the Medicaid utilization method established in 114.1 CMR 36.13(10)(b), the Commission will divide the hospital's Medicaid inpatient utilization rate calculated pursuant to 114.1 CMR 36.13(10)(b)2.d. by the threshold Medicaid inpatient utilization rate calculated pursuant to 114.1 CMR 36.13(10)(b)2.c. The ratio resulting from such division will be the federally-mandated Medicaid disproportionate share ratio.

b. For each hospital deemed eligible for the basic federally mandated Medicaid disproportionate share adjustment under the low-income utilization rate method, but not found to be eligible for the federally-mandated Medicaid disproportionate share adjustment under the Medicaid utilization method, the Commission will divide the hospital's low-income utilization rate by 25%. The ratio resulting from such division will be the federally-mandated Medicaid disproportionate share ratio.

c. The Commission will then determine, for the group of all eligible hospitals, the sum of federally-mandated Medicaid disproportionate share ratios calculated pursuant to 114.1 CMR 36.13(10)(b)5.a. and 114.1 CMR 36.13(10)(b)5.b.

d. The Commission will then calculate a minimum payment under the federally-mandated Medicaid disproportionate share adjustment requirement by dividing the amount of funds allocated pursuant to 114.1 CMR 36.13(10)(b)6. for payments under the federally-mandated Medicaid disproportionate share adjustment requirement by the sum of the federally-mandated Medicaid disproportionate share ratios calculated pursuant to 114.1 CMR 36.13(10)(b)5.c.

e. The Commission will then multiply the minimum payment under the federally-mandated Medicaid disproportionate share adjustment requirement by the federally-mandated Medicaid disproportionate share ratio established for each hospital pursuant to 114.1 CMR 36.13(10)(b)5.a. and b. The product of such multiplication will be the payment under the federally-mandated disproportionate share adjustment requirement. This payment ensures that each hospital's utilization rate exceeds one standard deviation above the mean, in accordance with 42 U.S.C. § 1396r-4.

36.13: continued

6. The total amount of funds allocated for payment to acute care hospitals under the federally-mandated Medicaid disproportionate share adjustment requirement will be $200,000 per year. These amounts will be paid by the Division of Medical Assistance, and distributed among the eligible hospitals as determined pursuant to 114.1 CMR 36.13(10)(b)5.e.

(c) Disproportionate Share Adjustment for Safety Net Providers. The Commission shall determine a disproportionate share safety net adjustment factor for all eligible hospitals, which takes into account the special circumstances of disproportionate share hospitals by adjusting Medicaid rates of payment in a manner to relieve the disproportionate burden of free care given by such hospitals.

1. Data Sources. The Commission will use free care charge data from the Department of Medical security, and total charges from the RSC-404. If the specified data source is unavailable, then the Commission shall determine and use the best alternative data source.

2. Eligibility of Federally-mandated Disproportionate Share Hospitals for the Safety Net Provider Adjustment. The disproportionate share adjustment for safety net providers is an additional payment for all hospitals eligible for the basic federally-mandated disproportionate share adjustment pursuant to 114.1 CMR 36.13(10)(b), which also meet the following additional criteria:

a. is a public hospital

b. has a volume of free care charges in FY91 which is at least 10% of its total charges.

c. is an essential safety net provider in its service area, as demonstrated by delivery of services to populations with special needs including persons with AIDS, trauma victims, high-risk neonates, and indigent patients without access to other providers

d. is in a municipality which has completed an agreement with the Division of Medical Assistance for intergovernmental transfer of funds to the Medicaid program for the federally-mandated disproportionate share adjustment for safety net providers.

3. Payment to Federally-mandated Disproportionate Share Hospitals under the Adjustment for Safety Net Providers. The Commission will calculate an additional adjustment for federally-mandated disproportionate share hospitals which are eligible for the safety net provider adjustment, pursuant to 114.1 CMR 36.13(10)(d)2. This adjustment shall be reasonably related to the costs, volume, or proportion of services provided to patients eligible for medical assistance under Title XIX, or to low-income patients, and shall be calculated as follows:

a. The Commission shall calculate for each eligible hospital, its rate year free care percentage of charges, by dividing the hospital's total net free care charged off by its total charges.

b. The federally-mandated disproportionate share adjustment for safety net providers shall equal one plus the free care percentage of charges calculated pursuant to 114.1 CMR 36.13(10)(d)3.a.

c. The federally-mandated disproportionate share adjustment for safety net providers shall not be in effect for any rate year in which Federal Financial Participation under Title XIX is unavailable for this payment.

(d) Uncompensated Care Disproportionate Share Adjustment. Hospitals eligible for this adjustment are those that report "free care costs," as defined by regulations of the Department of Medical Security (DMS), at or above the median free care costs relative to all acute hospitals participating in the free care pool administered by the Department of Medical Security pursuant to M.G.L. c. 118F. The payment amounts for eligible hospitals are determined by the Department of Medical Security in accordance with its regulations at 117 CMR 7.00. These payments will be made to eligible hospitals in accordance with Department of Medical Security regulations, the ISA between the Division of Medical Assistance, the Department of Medical Security, and the Comptroller's Office. Eligible hospitals will receive these payments on a periodic basis during the term of their Medicaid contract with the Division.